There does not seem to be any choice, according to Morris, between treatment by injection, on the one hand, and incision and excision on the other, either as to certainty of result or duration of treatment. It does not appear that either the thickness opacity of the sac, the great size of the tumor, the encysted nature of the hydrocele, or even failure of the iodine treatment constitute sufficiently good reason for a rejection of the latter in favor of incision and excision. But on the other hand, there seems to be nothing which need to deter the surgeon from incising or excising a hydrocele under either of the above conditions, unless it be that a cutting operation is objected to by the patient, or deemed dangerous in the individual case. A preference, however, may be given to incision or excision. (1) When we are in doubt as to the precise nature of the relations of the hydrocele sac, *e. g.*, as to whether it is a congenital hydrocele or a hydrocele of a hernial sac. (2) in some cases where hernia, whether reducible or irreducible complicates a hydrocele. (3) Where a foreign body in the tunica vaginalis is the cause of a hydrocele. (4) When, as in a case recently operated upon by Morris, a vaginal hydrocele is associated on the same side with an encysted hydrocele of the cord and a bubonocele. In this case excision of both the hydrocele and the hernial sac and closure of the pillars of the external abdominal ring were successfully accomplished at the same time.—*Am. Jour. Med. Science*, August, 1888.

G. R. FOWLER (Brooklyn).

II. On Inflammatory Diseases of the Seminal Vesicle. By JORDAN LLOYD (Birmingham). This paper is written with the view of showing:

1. That inflammatory disorders of the seminal vesicles and their ducts are not uncommon.

2. That they are in many respects analogous to inflammatory disease of the Fallopian tubes in women.

3. That while occurring sometimes primarily, they are, as a rule, secondary to inflammation of the urethra.

4. That the ejaculatory ducts may become obstructed and the seminal vesicles consequently hyper-distended.

5. That termination by suppuration is exceptional.

6. That when suppuration occurs it should be dealt with by incision from the perineum rather than from the rectum.

7. That gonorrhœa is by far the most common originator of these disorders.

8. That they are frequently concomitant with gonorrhœal epididymis.

9. That they are usually diagnosed as inflammations of the prostate or neck of the bladder.

10. That while certain suppurative phenomena are suggestive of them their diagnosis can only be made by objective examination from the rectum and bladder.—*Author's abstract of paper read at British Medical Asso. Meeting, Glasgow*, August, 1888.

JORDAN LLOYD (Birmingham).

III. Successful Case of Extirpation of the Kidney for Pyonephrosis. By Mr. KNOX (Glasgow). The patient, a woman, æt. 38 years, was admitted, with a large tumor in the left lumbar region; 12 months previously she had begun to experience much difficulty in micturition, accompanied with straining and pain above pubes. Urine was pale and muddy. Shivering fits occasionally occurred, with feverishness which lasted two days. During the last six months before admission the symptoms increased in severity. The appearance of the patient was barely healthy, and there was no anasarca. Pulse 100, regular; temperature normal. On examining the abdomen a large tumor occupied the left lumbar region, passing upward under costal arch, and downward to the crest of the illium. It was rounded, slightly movable with respiration, and on altering the position of the patient, distinctly fluctuant. The urine was acid, turbid when passed, and on handling deposited a thick layer of pus. The right urethra was catheterized and some clear, healthy urine obtained from it. The diagnosis of an abscess in the region of the left kidney having been made, the following operative interference was adopted. An incision was